



Provider Enrollment New Facility/Agency/Organization (FAO)

“Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time.”

-Provider Relations

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Register for MILogin and CHAMPS

MILogin is a website that allows a user to enter one ID and password in order to access multiple applications.

CHAMPS (Community Health Automated Medicaid Processing System) is the program where providers enroll, update enrollment information, and report services performed.

MILogin for Third Party

User ID

Password

Password

LOGIN

Don't have an account?

SIGN UP

Forgot your User ID?

Forgot your password?

Need Help?

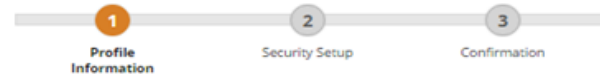
Copyright 2015-2019 State of Michigan

- Open your web browser (e.g. Internet Explorer, Google Chrome, Mozilla Firefox, etc.)
- Enter <https://milogintp.Michigan.gov> into the search bar
- Click Sign Up

MILogin for Third Party

[HOME](#)

Create Your Account



Profile Information

Enter your profile information

* Required

*First Name

Middle Initial

*Last Name

Suffix

*Email Address

*Confirm Email Address

*Work Phone Number

Mobile Number

*Verification Question: Bee, chin, ankle, leg and dog: how many body parts in the list?

☐

agree to the [terms & conditions](#).

NEXT

RESET

- Complete all required fields
- Check the 'I agree' box
- Click Next

MILogin for Third Party

HOME

Create Your Account



Security Setup

Provide user id and password information to complete your profile

* Required

* User ID

Enter a User ID

* Password

Enter password

* Confirm New Password

Confirm password

* Security Options

To choose your preferred password recovery method(s), please click on the buttons below. Multiple options can be selected.



CREATE ACCOUNT

BACK



User ID guideline:

- Enter your last name, first initial, and any 4 numbers with no space between them. For Example: John Smith and using 9999 as an example for the four digit number, you would enter smithj9999.

Password Guidelines:

- Must be at least 8 characters in length
- Must include characters from 3 of the following categories:
 - Upper case letters (A-Z)
 - Lower case letter (a-z)
 - Numbers (0-9)
 - Special characters (IS#,%@~^&*_-+=><)
- Should not be one of the last 3 used passwords
- Should not be based on your User ID

- Create the user ID and password following the listed guidelines
- Select the preferred password recovery method(s)
- Click Create Account

MILogin for Third Party

[HOME](#)

Create your account



Confirmation

✓ Success

Your account has been successfully created.

[LOGIN](#)

- Your MILogin account has now been created successfully
- Click the Login button to return to the login screen

MILogin for Third Party

User ID

Password

Password

LOGIN

Don't have an account?

SIGN UP

Forgot your User ID?

Forgot your password?

Need Help?

Copyright 2015-2019 State of Michigan

- Enter your User ID and Password you just created
- Click Login

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Home Page

⌚ Your password will expire in **364** days

Access your applications by clicking on the application links below

You do not have access to any application. You can request access by clicking on [Request Access](#) link.

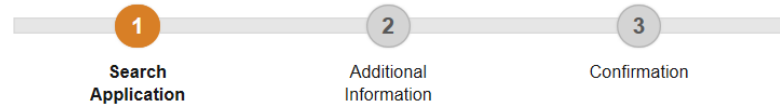
- Your Home Page will not show any applications
- Click Request Access

**MILogin resource links are listed at the bottom of the page*

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access



Search Application

Search for an application with a keyword or select an agency to view its applications

- Type CHAMPS in the search box
- Click the search/magnifying button

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access

1

Search
Application

2

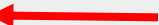
Additional
Information

3

Confirmation

Search Application

Search for an application with a keyword or select an agency to view its applications

**Michigan Department of Health & Human Services (MDHHS)****CHAMPS**

- Click on CHAMPS

MILogin for Third Party

HOME

Request A


Search App

Search for an applicati

CHAMPS

MDHHS Michigan

CHAMPS



CHAMPS

(Community Health Automated Medicaid Processing System) is the Michigan Medicaid Management Information System (MMIS). It supports Medicaid provider enrollment and maintenance, beneficiary healthcare eligibility and enrollment, prior authorization, Home Help Electronic Service Verification (ESV), fee-for-service payments and managed care enrollments, payments, and encounters.

General laws, rules and regulations. The systems are intended for use only by authorized persons and only for official state business. Systems users are prohibited from using any assigned or entrusted access control mechanisms for any purposes other than those required to perform authorized data exchange with MDHHS. Logon IDs and passwords are never to be shared. Systems users must not disclose any confidential, restricted or sensitive data to unauthorized persons. Systems users will only access information on the systems for which they have authorization. Systems users will not use MDHHS systems for commercial or partisan political purposes. Following industry standards, systems users must securely maintain any information downloaded, printed, or removed in any format from the systems. When no longer needed, this information must be destroyed in an appropriate manner specific to the format type. All users of the systems give their expressed consent to the monitoring of their activities on the systems. If such monitoring reveals possible evidence of unauthorized or criminal activity, the evidence may be provided to administrative or law enforcement officials for disciplinary action and/or

☒ I agree to the terms & conditions

☐ I do not agree

CANCEL ✕

REQUEST ACCESS

- Select the 'I agree to the terms & conditions' radio button
- Click Request Access

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access

1

✓ Search
Application

2

Additional
Information

3

Confirmation

Additional Information

Provide following information to submit your access request

* Required

*Email Address

*Work Phone Number

*CHAMPS User Type

- ☒ Provider/Other
☐ State User Only

SUBMIT**RESET**

- Verify all information is correct
- Click Submit

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Request Access

1

✓ Search
Application

2

✓ Additional
Information

3

Confirmation

Confirmation

✓ Success

The request for your access has been successfully submitted.

You will see the updated list of application(s) on your home page once it is processed.


[HOME](#)

- You will be given confirmation that your request has been submitted successfully
- Click the Home button to return to the MILogin Home Page

MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

Home Page

 Your password will expire in **48** days

Access your applications by clicking on the application links below

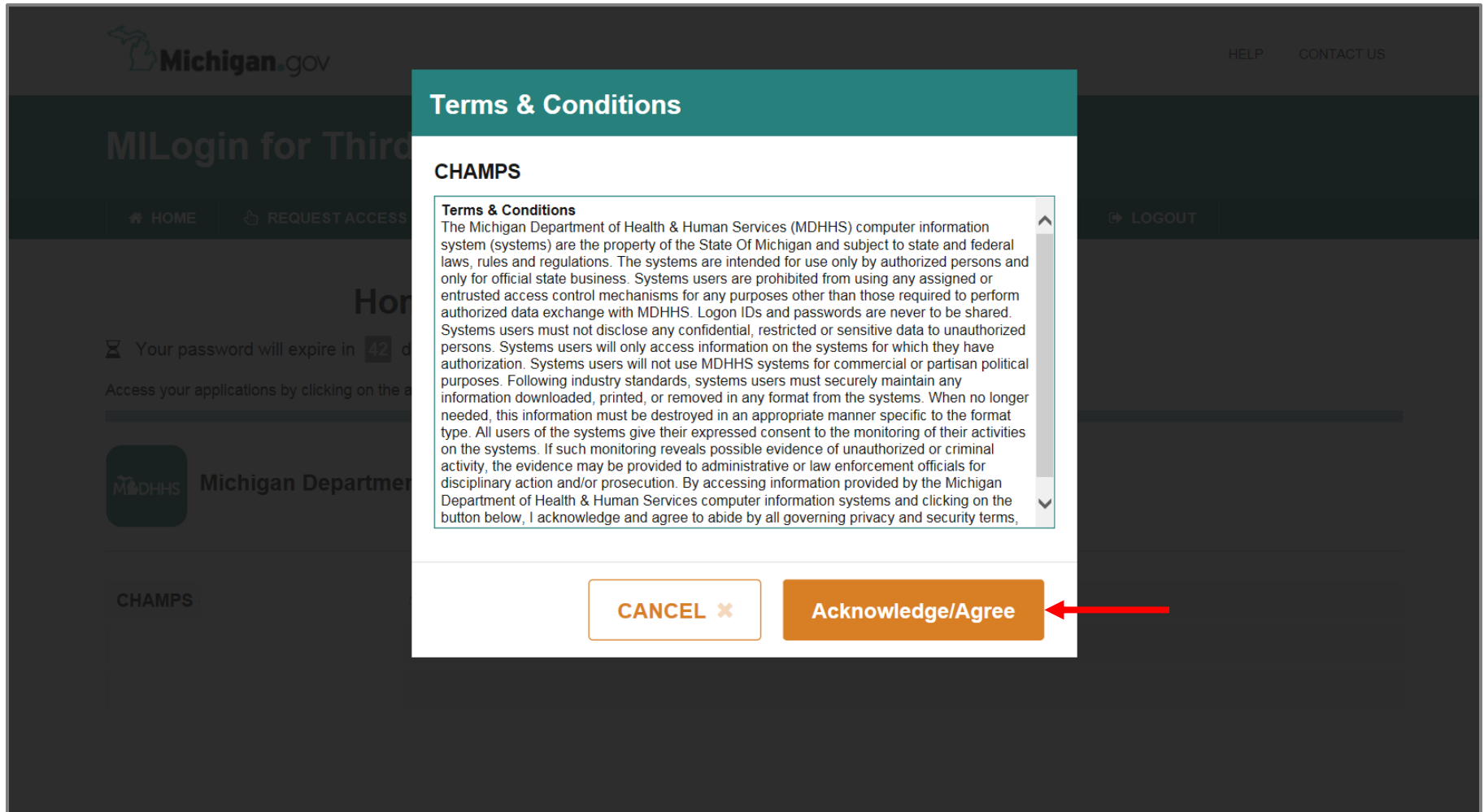


Michigan Department of Health & Human Services (MDHHS)

CHAMPS



- You will be directed back to your MILogin Home Page
- Click the CHAMPS hyperlink



- Click Acknowledge/Agree button to accept the Terms & Conditions to get into CHAMPS

New Provider Enrollment


Steps on how to complete a new CHAMPS enrollment for a Facility/Agency/Organization (FAO) Provider type

Prior to enrolling in CHAMPS

- FAO providers will want to ensure they are enrolled in SIGMA VSS prior to enrolling within CHAMPS.
 - SIGMA VSS website: www.michigan.gov/SIGMAVSS
 - If you have questions regarding this current process, contact the Vendor Support Call Center at 1-888-734-9749 or email SIGMA-Vendor@Michigan.gov
 - After completing SIGMA registration allow 3-5 business days to begin and complete the CHAMPS application. If you attempt to enroll in CHAMPS during this time you may get an error when validating your information.
- FAO providers must also be licensed prior to enrolling in CHAMPS
 - LARA: <http://www.michigan.gov/lara/0,4601,7-154-72600---,00.html>



Provider Enrollment

 [New Enrollment](#)

Enroll As A New Provider

[Track Application](#)

Track Existing Provider Application

- Click New Enrollment

Enrollment Type

Select the Applicable Enrollment Type

- ☐ Individual/Sole Proprietor
 - ☐ Regular Individual/Sole Proprietor or Rendering/Service Provider
- ☐ Group Practice (Corporation, Partnership, LLC, etc.)
- ☐ Billing Agent
- ☒ Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities) ←
- ☐ Atypical (non-medical) provider (Choose this option if you do not have a NPI)
 - ☐ Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
 - ☐ Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)

Submit

- Select Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)
- Click Submit

CHAMPS < Provider ▾

Basic Information 1 - Google Chrome

Provider Portal > tp-chp-uat.state.mi.us/ecams/CNS/ControlServlet

Print Help

Basic Information: Enter required fields and click Confirm button.

Basic Information

Legal Entity Name: (As shown on the Income Tax Return)

Entity Business Name: * (Doing Business As)

EIN/TIN: *

Organization/Business Type: *

Vendor ID: *

Medicare Cost Share: ☐

NPI: *

Contact Email Address:

Email-1: * Email-2:

Email-3: Email-4:

Email-5: Email-6:

Confirm Finish Cancel

Page ID: dlqAddBasicInformationStep1(Provider)

- Complete all fields marked with an asterisk (*)
- Click Confirm
- Click Finish

The screenshot shows a web browser window with the address bar displaying <https://milogintpqa.michigan.gov/> and the page title "Welcome to MMIS - Internet Explorer". The CHAMPS logo is in the top left corner, and a "Provider" dropdown menu is next to it. A dark blue navigation bar contains "Print" and "Help" icons. Below this, a light gray header bar shows "Application ID: 20181204526214" and "Name: Testing". The main content area is titled "Basic Information" and contains the following text:

You have successfully completed the basic information on the Enrollment Application.

Your Application ID is: **20181204526214**

Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.

Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.

An "Ok" button is located in the bottom right corner of the content area. A black footer bar at the bottom of the page displays "Page ID: dlgAddBasicInformationStep3(Provider)".

- Confirmation, Basic Information is complete
- Take note of the Application ID, as this is used to track your application status
- Click Ok



Provider ▾



Last Login: 04 DEC, 2018 01:01 PM

Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing

Close



Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | | | Incomplete | |
| Step 3: Add Specialties | Required | | | Incomplete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Optional | | | Incomplete | |
| Step 6: Add Additional Information | Optional | | | Incomplete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | | | Incomplete | |
| Step 8: Associate Billing Agent | Optional | | | Incomplete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 10: Add Taxonomy Details | Required | | | Incomplete | |
| Step 11: Associate MCO Plan | Optional | | | Incomplete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1


First

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Next

Last


- FAO Provider Enrollment steps are listed (Please Note: some steps are required versus optional)
- Step 1 has a status of Complete
- Click on Step 2: Add Locations





Provider





Last Login: 04 DEC, 2018 01:01 PM

 Note Pad

 External Links

 My Favorites


 Print


 Help

[New Enrollment](#) > [FAO Enrollment](#)


Application ID: 20181204526214

Name: Testing


 Close


 Add


To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink





 Locations List

Filter By

 Go

 Save Filters

 My Filters

| Doing Business As | Location Type | Location Details | End Date |
|--|---|---|---|
|  |  |  |  |
| No Records Found ! | | | |

- Click Add, to enter Primary Location information

CHAMPS Provider

https://milogintpq.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20181204526214 Name: Testing

For all locations, Correspondence address is required. For Primary Practice Location, Pay-To address is required. Enter Remittance Advice address only to receive a paper Remittance Advice.

Add Provider Location

Location Type: Primary Practice Location *

Doing Business As: End Date:

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWER 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2: Address Line 3:

City/Town: OTHER *
County: OTHER *
Zip Code: * - Validate Address

State/Province: OTHER *
Country: UNITED STATES *

Phone Number: * Extn: Fax Number: Web Page: Communication Preference:

Email Address:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

| Day: | Open At: | AM/PM | Close At: | AM/PM | Day: | Open At: | AM/PM | Close At: | AM/PM |
|------------|----------|---------|-----------|---------|-----------|----------|---------|-----------|---------|
| Sunday: | * | AM PM * | * | AM PM * | Thursday: | * | AM PM * | * | AM PM * |
| Monday: | * | AM PM * | * | AM PM * | Friday: | * | AM PM * | * | AM PM * |
| Tuesday: | * | AM PM * | * | AM PM * | Saturday: | * | AM PM * | * | AM PM * |
| Wednesday: | * | AM PM * | * | AM PM * | | | | | |

Handicap Accessible: No Accept 835 (reported at EIN/TIN level): No

Language(s) Spoken: English Arabic Chinese (For Multiple Selection, use Ctrl Key)


Facility Details

State Facility ID: Fiscal Year End Date: *
(mm/dd)

Page ID: dlgEnrAddLocation(Provider)

OK Cancel

- Complete Address Line 1 and Zip Code, click Validate Address
(Please Note: you should receive confirmation "Address Validation Successful")
- Complete all fields marked with an asterisk (*)
- Click Ok


Provider ▾

Last Login: 04 DEC, 2018 01:01 PM
Note Pad
External Links ▾
My Favorites ▾
Print
Help

New Enrollment
FAO Enrollment

Application ID: 20181204526214
Name: Testing

Close
Add
To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink

Locations List

Filter By ▾
Go
Save Filters
My Filters ▾

| Doing Business As | Location Type | Location Details | End Date |
|-----------------------------|--|---|---|
| <input type="checkbox"/> ▲▼ | <input type="checkbox"/> ▲▼ Primary Practice Location | <input type="checkbox"/> ▲▼ 320 S Walnut St, Lansing, MICHIGAN 48933 | <input type="checkbox"/> ▲▼ 12/31/2999 |

Delete
View Page: 1
Go
Page Count
SaveToXLS
Viewing Page: 1
First
Prev
Next
Last

- Click Primary Practice Location to add Pay-To address
(Please Note: Correspondence address is required for all locations. Enter Remittance Advise address only to receive a paper Remittance Advice)

Application ID: 20181204526214

Name: Testing

 To add additional addresses, click "Add Address" button.

Location Details

Doing Business As:

Location Code: 1

Location Type: Primary Practice Location

Phone Number: (333) 333-3333 * Extn: Fax Number: Email Address: Web Page: Communication

Preference:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

| Day: | Open At: | AM/PM | Close At: | AM/PM | Day: | Open At: | AM/PM | Close At: | AM/PM |
|------------|------------------------------------|---------------------------------|------------------------------------|---------------------------------|-----------|------------------------------------|---------------------------------|-------------------------------|---------------------------------|
| Sunday: | <input type="text" value="Close"/> | <input type="text" value="AM"/> | <input type="text" value=""/> | <input type="text" value="PM"/> | Thursday: | <input type="text" value="Close"/> | <input type="text" value="AM"/> | <input type="text" value=""/> | <input type="text" value="PM"/> |
| Monday: | <input type="text" value="07:00"/> | <input type="text" value="AM"/> | <input type="text" value="04:30"/> | <input type="text" value="PM"/> | Friday: | <input type="text" value="Close"/> | <input type="text" value="AM"/> | <input type="text" value=""/> | <input type="text" value="PM"/> |
| Tuesday: | <input type="text" value="07:00"/> | <input type="text" value="AM"/> | <input type="text" value="04:30"/> | <input type="text" value="PM"/> | Saturday: | <input type="text" value="Close"/> | <input type="text" value="AM"/> | <input type="text" value=""/> | <input type="text" value="PM"/> |
| Wednesday: | <input type="text" value="07:00"/> | <input type="text" value="AM"/> | <input type="text" value="04:30"/> | <input type="text" value="PM"/> | | | | | |

Handicap Accessible: Accept 835(reported at EIN/TIN level): Language(s) Spoken:
(For Multiple Selection, use Ctrl Key)End Date:

Facility Details

State Facility ID: Fiscal Year End Date:

(mm/dd)

Address List

| Address Type | Address | End Date |
|-----------------------------------|--|------------|
| <input type="checkbox"/> Location | 320 S Walnut St, Lansing, MICHIGAN 48933 | 12/31/2999 |

 View Page:

Viewing Page: 1

- Click Add Address

Application ID: 20171106185367

Name: Testing

Add Provider Location Address

Type of Address: --SELECT--

End Date: Location Address: ☐ Copy This Location Address

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWER 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

Address Line 1: *

(Enter Street Address or PO Box Only)

Address Line 2:

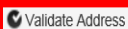
Address Line 3:

City/Town: OTHER *

State/Province: OTHER *

County: OTHER *

Country: UNITED STATES *

Zip Code:  

- From the drop-down list, select Type of Address
- Complete all fields marked with an asterisk (*)
- Click Validate Address

(Please Note: you should receive confirmation "Address Validation Successful")

- Click Ok

CHAMPS < Provider ▾

Last Login: 04 DEC, 2018 01:01 PM

Note Pad External Links ▾ My Favorites ▾ Print Help

> New Enrollment > FAO Enrollment > General

Application ID: 20181204526214 Name: Testing

Close Save To add additional addresses, click "Add Address" button.

Location Details

Doing Business As:

Phone Number: (333) 333-3333 * Extn:

Web Page:

Location Code: 1

Fax Number:

Location Type: Primary Practice Location

Email Address:

Communication Preference:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

| Day: | Open At: | AM/PM | Close At: | AM/PM | Day: | Open At: | AM/PM | Close At: | AM/PM |
|------------|-----------|---------|-----------|---------|-----------|-----------|---------|-----------|---------|
| Sunday: | Close ▾ * | AM PM * | ▾ * | AM PM * | Thursday: | Close ▾ * | AM PM * | ▾ * | AM PM * |
| Monday: | 07:00 ▾ * | AM PM * | 04:30 ▾ * | AM PM * | Friday: | Close ▾ * | AM PM * | ▾ * | AM PM * |
| Tuesday: | 07:00 ▾ * | AM PM * | 04:30 ▾ * | AM PM * | Saturday: | Close ▾ * | AM PM * | ▾ * | AM PM * |
| Wednesday: | 07:00 ▾ * | AM PM * | 04:30 ▾ * | AM PM * | | | | | |

Handicap Accessible: No ▾

Accept 835(reported at EIN/TIN level): No ▾

Language(s) Spoken: English Arabic Chinese ▾
(For Multiple Selection, use Ctrl Key)

End Date: 12/31/2999

Facility Details

State Facility ID:

Fiscal Year End Date: 12/31 *
(mm/dd)

Address List

Add Address

| Address Type | Address | End Date |
|--|---------|------------|
| <input type="checkbox"/> Correspondence | | 12/31/2999 |
| <input type="checkbox"/> Location | | 12/31/2999 |
| <input type="checkbox"/> Primary Pay To | | 12/31/2999 |
| <input type="checkbox"/> Remittance Advice | | 12/31/2999 |

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1

« First « Prev » Next » Last

- When all address locations are complete, click Save
(Please Note: If the address is the same you can click on the radio button that says, Copy This Location Address; example on previous slide.)

- Click Close



Provider ▾



Last Login: 04 DEC, 2018 01:01 PM

Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

Home > New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing



Close



Add

To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink



Locations List



Filter By



Go



Save Filters



My Filters ▾

Doing Business As

Location Type

Location Details

End Date



[Primary Practice Location](#)

320 S Walnut St, Lansing, MICHIGAN 48933

12/31/2999



Delete

View Page:

1



Go



Page Count



SaveToXLS

Viewing Page: 1



First



Prev



Next



Last

- Click Close



Provider ▾



Last Login: 04 DEC, 2018 01:01 PM

Note Pad

External Links ▾

★ My Favorites ▾

Print

Help

New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing

Close



Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | | | Incomplete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Optional | | | Incomplete | |
| Step 6: Add Additional Information | Optional | | | Incomplete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | | | Incomplete | |
| Step 8: Associate Billing Agent | Optional | | | Incomplete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 10: Add Taxonomy Details | Required | | | Incomplete | |
| Step 11: Associate MCO Plan | Optional | | | Incomplete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

View Page: 1

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Next >

>> Last

- Step 2 is complete
- Click on Step 3: Add Specialties



Provider ▾



Last Login: 04 DEC, 2018 01:01 PM

Note Pad

External Links ▾

My Favorites ▾

Print

Help

> [New Enrollment](#) > [FAO Enrollment](#)

Application ID: 20181204526214

Name: Testing

Close

Add



Specialty/Subspecialty List



Filter By



Go

Save Filters

My Filters ▾

Specialty/Subspecialty

Provider Type

End Date



No Records Found !

- Click Add

CHAMPS Provider

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171106185367 Name: Testing

Add Specialty/Subspecialty

Location: 01- *
Provider Type: ---SELECT--- *
Specialty: *
End Date:

Add Subspecialty

Available Subspecialties Associated Subspecialties *

»
«

OK Cancel

- Choose appropriate Location, Provider Type, and Specialty
(Please Note: There is no need to fill in an End Date)
- Dependent on the Specialty chosen, Available Subspecialties will populate

CHAMPS Provider

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171106185367 Name: Testing

Add Specialty/Subspecialty


Location: 01- *
Provider Type: SUPPLIERS *
Specialty: Medical Supply Company *
End Date:

Add Subspecialty

| Available Subspecialties | | Associated Subspecialties * |
|--|----------|-----------------------------|
| DIS Contract With Licensed Pharmacy With Orthotics Personnel With Registered Pharmacist With Respiratory Therapist | >> << | No Subspecialty |

OK Cancel

- When Provider Type and Specialty have been chosen, the available subspecialties will be listed
- Select Available Subspecialties, click >> to add to Associated Subspecialties list
- When complete, click Ok


Provider ▾

Quick Find
Note Pad
External Links ▾
My Favorites ▾
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Help

New Enrollment
FAO Enrollment

Application ID: 20171106185367
Name: Testing

Close Add

Specialty/Subspecialty List

Filter By ▾

Go
Save Filters
My Filters ▾

| Specialty/Subspecialty | Provider Type | End Date |
|---|------------------------------|------------------------------|
| <input type="checkbox"/> ▴ ▾ | <input type="checkbox"/> ▴ ▾ | <input type="checkbox"/> ▴ ▾ |
| <input type="checkbox"/> Medical Supply Company/No Subspecialty | SUPPLIERS | 12/31/2999 |

Delete
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- Once all Specialties/Subspecialties have been added, click Close



Provider ▾



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New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing

Close



Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|--|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Required | | | Incomplete | Please add required License/Certification. |
| Step 6: Add Additional Information | Optional | | | Incomplete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | | | Incomplete | |
| Step 8: Associate Billing Agent | Optional | | | Incomplete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 10: Add Taxonomy Details | Required | | | Incomplete | |
| Step 11: Associate MCO Plan | Optional | | | Incomplete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 3 is complete
- Click on Step 4: Associate Billing Provider/Other Associations



Provider ▾



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Home > New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing

Close

Add



Billing Provider/Other Associations List

Filter By



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NPI/Provider ID

Provider Name

Enrollment Type

Start Date

End Date

Status



No Records Found !

- Click Add

CHAMPS

Provider

https://milogintpqa.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20181204526214 Name: Testing

Associate Billing Provider/Other Associations

Enter NPI/Provider ID of Billing Provider/Other Associations and click "Confirm Provider."

Type: *

ID: *

Start Date: *

Provider Name:

Enrollment Type:

Applicant Type:

End Date: *

Confirm Provider Ok Cancel

Page ID: dlgBillingProviderID(Provider)

- Complete all fields marked with an asterisks (*)
- Click Confirm Provider
 - Provider Name and Enrollment Type will populate
- Click Ok



Provider ▾



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Print

Help

New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing

Close

Add



Billing Provider/Other Associations List

Filter By



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| NPI/Provider ID ▲▼ | Provider Name ▲▼ | Enrollment Type ▲▼ | Start Date ▲▼ | End Date ▲▼ | Status ▲▼ |
|--------------------------|---------------------|---|------------------|----------------|--------------|
| <input type="checkbox"/> | | Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities) | 12/03/2018 | 12/31/2999 | Approved |

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- Once all Billing Provider/Other Associations have been added, click Close



Provider ▾



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New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing

Close



Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|--|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | | | Incomplete | Please add required License/Certification. |
| Step 6: Add Additional Information | Optional | | | Incomplete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | | | Incomplete | |
| Step 8: Associate Billing Agent | Optional | | | Incomplete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 10: Add Taxonomy Details | Required | | | Incomplete | |
| Step 11: Associate MCO Plan | Optional | | | Incomplete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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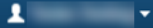
Next

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- Step 4 is complete
- Click on Step 5: Add License/Certification/Other



Provider ▾



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Home > New Enrollment > FAO Enrollment

Application ID: 20171106185367

Name: Testing

Close

Add



License/Certification/Other List



Filter By



Go

Save Filters

My Filters ▾

License/Cert./Other Type

License/Cert./Other #

Valid Flag

Effective Date

End Date



No Records Found !

- Click Add

CHAMPS < Provider ▾

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Print Help

Application ID: 20171106185367 Name: Testing

Add License/Certification/Other

Location: 01- ▾ *

License/Certification/Other Type: ▾ *

License/Certification/Other #: ▾ *

Valid Flag: ▾ *

Effective Date: ▾ *

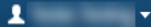
End Date: ▾ *

Confirm License/Certification/Other OK Cancel

- Complete all fields marked with an asterisk (*)
- Click Confirm License/Certification/Other
- Click Ok



Provider▼



Quick Find

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New Enrollment > FAO Enrollment

Application ID: 20171106185367

Name: Testing

Close Add

License/Certification/Other List

Filter By



Go

Save Filters

My Filters▼

| License/Cert./Other Type | License/Cert./Other # | Location | Valid Flag | Effective Date | End Date |
|---|-----------------------|----------|------------|----------------|------------|
| <input type="checkbox"/> ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ |
| <input type="checkbox"/> Medicare Certification | 111111111 | 01- | Yes | 12/01/2012 | 12/31/2999 |

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- The License/Certification/Other information will now be displayed
- To add another License/Certification repeat the same process
- Click Close



Provider ▾



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New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing

Close

Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | | | Incomplete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | | | Incomplete | |
| Step 8: Associate Billing Agent | Optional | | | Incomplete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 10: Add Taxonomy Details | Required | | | Incomplete | |
| Step 11: Associate MCO Plan | Optional | | | Incomplete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 5 is complete
- Click on Step 6: Add Additional Information
(Please Note: Depending on the specialty chosen in step 3, this step may be required)


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New Enrollment
FAO Enrollment

Application ID: 20171106185367
Name: Testing

Close

Contact List

Add

Filter By
Go
Save Filters
My Filters

| Contact Type | First Name | Last Name | Address | Location Name | Start Date | End Date |
|--------------------|------------|-----------|---------|---------------|------------|----------|
| No Records Found ! | | | | | | |

Identifier List

Add

Filter By
Go
Save Filters
My Filters

| Identifier Type | Identifier Value | Location Name | Start Date | End Date |
|--------------------|------------------|---------------|------------|----------|
| No Records Found ! | | | | |

Bed Information

Add

Filter By
Go
Save Filters
My Filters

| Bed Type | Bed(s)/Unit(s) | Location Name | Start Date | End Date |
|--------------------|----------------|---------------|------------|----------|
| No Records Found ! | | | | |

- Under Contact List, click Add

(Please Note: Providers have to at least fill in the General contact for Type of Contact. These contacts can be the same as the Owners.)

CHAMPS < Provider ▾

https://milogintpmichigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171106185367 Name: Testing

Add Contact

Location: 01- ▾ *

Type of Contact: ---SELECT--- ▾ *

Title: ---SELECT--- ▾ *

First Name: *

Last Name: *

Phone Number: *

Fax Number:

Email Id:

Start Date: *

End Date:

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: OTHER ▾ *

State/Province: OTHER ▾ *

County: OTHER ▾

☒ OK

- Complete all fields marked with an asterisk (*)
- Click Validate Address (*Please Note: you should receive confirmation "Address Validation Successful"*)
- Click Ok

New Enrollment > FAO Enrollment

Application ID: 20171106185367

Name: Testing

Close

Contact List

Add

Filter By

Go

Save Filters

My Filters

| Contact Type | First Name | Last Name | Address | Location Name | Start Date | End Date |
|--|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| <input type="checkbox"/> ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ |
| <input type="checkbox"/> General | | | | | 11/01/2017 | 12/31/2999 |

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Identifier List

Add

Filter By

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Save Filters

My Filters

| Identifier Type | Identifier Value | Location Name | Start Date | End Date |
|--|------------------|-----------------|-----------------|-----------------|
| <input type="checkbox"/> ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ |
| No Records Found ! | | | | |

Bed Information

Add

Filter By

Go

Save Filters

My Filters

| Bed Type | Bed(s)/Unit(s) | Location Name | Start Date | End Date |
|--|-----------------|-----------------|-----------------|-----------------|
| <input type="checkbox"/> ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ |
| No Records Found ! | | | | |

- Under Identifier List, click Add

CHAMPS < Provider ▾

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Print Help

Application ID: 20171106185367 Name: Testing

Add Identifier

Identifier Type: School Code ▾ *

Location: 01- ▾ *

Identifier Value: *

Notes:

Start Date: *

End Date:

- Complete all fields marked with an asterisk (*)
- Click Ok

Provider

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New Enrollment
FAO Enrollment

Application ID: 20171106185367
Name: Testing

Close

Contact List

Add

Filter By
Go
Save Filters
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| Contact Type | First Name | Last Name | Address | Location Name | Start Date | End Date |
|---|------------|-----------|---------|---------------|------------|------------|
| <input type="checkbox"/> General | | | | | 11/01/2017 | 12/31/2999 |

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Identifier List

Add

Filter By
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Save Filters
My Filters

| Identifier Type | Identifier Value | Location Name | Start Date | End Date |
|---|------------------|---------------|------------|------------|
| <input type="checkbox"/> School Code | | | 11/01/2017 | 12/31/2999 |

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Bed Information

Add

Filter By
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Save Filters
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| Bed Type | Bed(s)/Unit(s) | Location Name | Start Date | End Date |
|--------------------|----------------|---------------|------------|----------|
| No Records Found ! | | | | |

- Bed Information may also be required depending on the specialty
- Under Bed Information, click Add

CHAMPS < Provider ▾

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Print Help

Application ID: 20171106185367 Name: Testing


Add Bed Information

Location: 01- ▾ *

Bed Type: ---SELECT--- ▾ *

Start Date:  *

Bed(s)/Unit(s): *

End Date:  *

- Complete all fields marked with an asterisk (*)
- Click Ok



Provider ▾



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New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing

Close



Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | | | Incomplete | |
| Step 8: Associate Billing Agent | Optional | | | Incomplete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 10: Add Taxonomy Details | Required | | | Incomplete | |
| Step 11: Associate MCO Plan | Optional | | | Incomplete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 6 is complete
- Click on Step 7: Add Mode of Claim Submission/EDI Exchange

Application ID: 20171106185367

Name: Testing

Mode of Claims Submission/EDI exchange

Please select the submission methods from EDI Exchange and/or Other Claims Submission as applicable.

EDI exchange

| Method | Description | Applicable Transactions |
|---|---|--|
| <input type="checkbox"/> Electronic Batch | To upload/download HIPAA transactions from screens (Maximum file upload size is 50MB) | 837P- Professional (FFS), 837I -Institutional(FFS), 837D -Dental(FFS), 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response |
| <input type="checkbox"/> CORE Batch | To upload/download HIPAA transactions using CORE Batch Connectivity | 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 835 Health Care Claim Payment/Advice |
| <input type="checkbox"/> CORE Real Time | To upload/download HIPAA transactions using CORE Real Time Connectivity | 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response |
| <input type="checkbox"/> Billing Agent | To submit/receive HIPAA transactions through billing agent | 837P- Professional (FFS/Encounter), 837I -Institutional(FFS/Encounter), 837D -Dental(FFS/Encounter), 270/271 -Eligibility Inquiry/Response, 276/277-Claim Status Inquire/Response, 278/278- Prior Authorization Request/Response, 835- Healthcare Claim payment Advice |

Other Claims Submission

| Method | Description |
|---|---|
| <input type="checkbox"/> Paper Claims | To submit FFS paper claims |
| <input type="checkbox"/> Direct Data Entry(DDE) | To submit FFS claims via online screens |

- Under EDI exchange select appropriate claim submission method(s)
- Under Other Claims Submission select appropriate claim submission method(s)
- Click Ok



Provider ▾



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New Enrollment > FAO Enrollment

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Name: Testing

Close

Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|--|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 8: Associate Billing Agent | Required | | | Incomplete | Please associate required Billing Agent. |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 10: Add Taxonomy Details | Required | | | Incomplete | |
| Step 11: Associate MCO Plan | Optional | | | Incomplete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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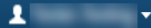
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- Step 7 is complete
- Click on Step 8: Associate Billing Agent



Provider ▾



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Home > New Enrollment > FAO Enrollment

Application ID: 20171106185367

Name: Testing

Close

Add



Billing Agent List

Filter By



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Billing Agent ID

Billing Agent Name

835 Authorization

Start Date

End Date



No Records Found !

- Click Add

CHAMPS < Provider ▾

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Application ID: 20171106185367 Name: Testing

Associate Billing Agent

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

Billing Agent ID: * Billing Agent Name:

Association Start Date: * Association End Date:

Authorized Transaction Responses

| Transaction Response | Authorized | Start Date | End Date |
|-----------------------------------|--------------------------|----------------------|----------------------|
| X12 835 - Healthcare Claim Status | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> |

- To locate Billing Agent information, click Confirm/Search Billing Agent

CHAMPS Provider

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Print Help

https://milogintp.michigan.gov/ - Search Billing Agent List - Internet Explorer

Print Help

Application ID: 20171106185367 Name: Testing

Billing Agent List

Filter By [] [] Go Save Filters My Filters

| Billing Agent ID | Billing Agent Name | Start Date | End Date |
|--------------------------|--------------------|------------|------------|
| <input type="checkbox"/> | | 01/01/1984 | 12/31/2999 |
| <input type="checkbox"/> | | 01/01/1984 | 12/31/2999 |
| <input type="checkbox"/> | | 04/30/1998 | 12/31/2999 |
| <input type="checkbox"/> | | 12/08/1999 | 12/31/2999 |
| <input type="checkbox"/> | | 02/25/2000 | 12/31/2999 |
| <input type="checkbox"/> | | 06/04/1999 | 12/31/2999 |
| <input type="checkbox"/> | | 02/19/2002 | 12/31/2999 |

Select Close

- Check the box next to the Billing Agent you want to select
(Please Note: There is more than one page of Billing Agents; you may select more than one)
- Click Select

Application ID: 20171106185367

Name: Testing

Associate Billing Agent

Click on the 'Confirm/Search Billing Agent' button to search for a Billing Agent or confirm the Billing Agent entered.

Billing Agent ID: *Billing Agent Name: Association Start Date: 11/07/2017 *Association End Date: 12/31/2999

Authorized Transaction Responses

| Transaction Response | Authorized | Start Date | End Date |
|-----------------------------------|--------------------------|----------------------|----------------------|
| X12 835 - Healthcare Claim Status | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> |

- Billing Agent information will populate
- Click Ok



Provider▼

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New Enrollment > FAO Enrollment

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Name: Testing

Close

Add

Billing Agent List

Filter By



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Save Filters

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| Billing Agent ID | Billing Agent Name | 835 Authorization | Start Date | End Date |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> ▲▼ | <input type="checkbox"/> ▲▼ | <input type="checkbox"/> ▲▼ | <input type="checkbox"/> ▲▼ | <input type="checkbox"/> ▲▼ |
| <input type="checkbox"/> | | No | 11/07/2017 | 12/31/2999 |

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- Billing Agent information has been added
- Click Close



Provider ▾



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Close



Enroll Provider - FAO

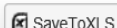
Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 8: Associate Billing Agent | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 10: Add Taxonomy Details | Required | | | Incomplete | |
| Step 11: Associate MCO Plan | Optional | | | Incomplete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 8 is complete
- Click on Step 9: Add Provider Controlling Interest/Ownership Details
 - *The screens for this step were updated 12/14/18

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PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:
 - Corporate - Charitable 501(c)3
 - Corporate - Non Charitable
 - Corporate - Publicly Traded
 - Corporate - Not Publicly Traded
 - Sub-contractor
 - Holding Company
 - Foreign, Nonresident Alien
 - Limited liability Company
 - Indirect Owner

Owners List

Filter By And Go Save Filters My Filters

| Owner SSN/EIN/TIN | Owner Information | Owner Type | Address | Start Date | End Date | Relationship Status | Adverse Action | Percentage owned |
|--------------------------|-------------------|------------|---------|------------|----------|---------------------|----------------|------------------|
| <input type="checkbox"/> | | | | | | | | |

No Records Found !

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By Go Save Filters My Filters

| Other Owner EIN/TIN | Other Owner Information | Address |
|--------------------------|-------------------------|---------|
| <input type="checkbox"/> | | |

No Records Found !

- To enter owner information, click Actions

Provider

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Owners Adverse Action

PROVIDER DISCLOSURES
Provider E
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REQUIRED OWNERS
Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501(c)3
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 - Corporate - Charitable 501(c)3
 - Corporate - Non Charitable
 - Corporate - Publicly Traded
 - Corporate - Not Publicly Traded
 - Sub-contractor
 - Holding Company
 - Foreign, Nonresident Alien
 - Limited liability Company
 - Indirect Owner

Owners List

Filter By
And
Go
Save Filters
My Filters

| Owner SSN/EIN/TIN | Owner Information | Owner Type | Address | Start Date | End Date | Relationship Status | Adverse Action | Percentage owned |
|--------------------|-------------------|------------|---------|------------|----------|---------------------|----------------|------------------|
| No Records Found ! | | | | | | | | |

Add Other Owned Entity
List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By
Go
Save Filters
My Filters

| Other Owner EIN/TIN | Other Owner Information | Address |
|---------------------|-------------------------|---------|
| No Records Found ! | | |

- Select Add Owner

CHAMPS Provider

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Application ID: 20181204526214 Name: Testing

Provider Controlling Interest/Ownership

Type: *

Percentage Owned: *

SSN:

EIN/TIN:

Legal Entity Name:
(As shown on the Income Tax Return)

Entity Business Name:
(Doing Business As)

Owner NPI:

First Name:

Last Name:

Suffix:

DOB:

Phone Number: * **Extn:**

Email:

Start Date: *

End Date:

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: * -

Page ID: dlGEnrlmntAddOwner(Provider)

- Select an Owner Type from the drop-down menu
- Complete all fields marked with an asterisk (*)
- Complete Address Line 1 and Zip Code, click Validate Address
(Please Note: you should receive confirmation "Address Validation Successful")
- Click Ok

CHAMPS < Provider ▾

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Close Actions ?

Pe Add Owner

PROVIDE Import Owner

Provider E Owners Relationships

REQUIRE Owners Adverse Action

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501[c]3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

| | | |
|--------------------------------|---------------------------------|----------------------------|
| Corporate - Charitable 501[c]3 | Corporate - Not Publicly Traded | Foreign, Nonresident Alien |
| Corporate - Non Charitable | Sub-contractor | Limited liability Company |
| Corporate - Publicly Traded | Holding Company | Indirect Owner |

Owners List

Filter By ▾ And Go

Save Filters My Filters ▾

| Owner SSN/EIN/TIN | Owner Information | Owner Type | Address | Start Date | End Date | Relationship Status | Adverse Action | Percentage owned |
|--------------------------|--------------------|--|-------------------|------------|------------|---------------------|----------------|------------------|
| <input type="checkbox"/> | Employee, Managing | Managing Employee | 100 N Capitol Ave | 12/03/2018 | 12/31/2999 | Not Completed | Not Completed | 0 |
| <input type="checkbox"/> | CEO, CEO | Board of Directors/Officers/Principles | 100 N Capitol Ave | 12/03/2018 | 12/31/2999 | Not Completed | Not Completed | 0 |
| <input type="checkbox"/> | Testing CO | Corporate - Charitable 501[c]3 | 100 N Capitol Ave | 12/03/2018 | 12/31/2999 | Not Completed | Not Completed | 100 |

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

Add Other Owned Entity List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By ▾ Go

Save Filters My Filters ▾

| Other Owner EIN/TIN | Other Owner Information | Address |
|--------------------------|-------------------------|---------|
| <input type="checkbox"/> | | |

No Records Found !

- Added Owner(s) will be listed. Click on Add Owner until all required Owner Types are added.
 - For further clarification on required owner types click [here](#).
- Once complete, click Actions
- Select Owners Relationships

CHAMPS Provider

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Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☐ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner: Testing CO SSN/EIN/TIN: Status: Not Completed

| Assoc. Owner | SSN/EIN/TIN | Type | Relation to Testing CO | Relation to Assoc. Owner |
|--------------------|-------------|--|------------------------|--------------------------|
| CEO, CEO | | Board of Directors/Officers/Principles | | |
| Employee, Managing | | Managing Employee | | |

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Selected Owner: CEO, CEO SSN/EIN/TIN: Status: Not Completed

Selected Owner: Employee, Managing SSN/EIN/TIN: Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- Answer question (at the top)
- If no relationships exist select No, click Save, read the pop-up message, select Ok, and Close.
 - Skip to [slide 72](#)
- If relationships exist select Yes, and continue

CHAMPS < Provider ▾

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Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☒ Yes ☐ No (Click Save to update)

Owner List

Show Owners All ▾ Go

Save Filters My Filters ▾

▼ **Selected Owner: Testing CO** SSN/EIN/TIN: ██████████ Status: Completed

| Assoc. Owner | SSN/EIN/TIN | Type | Relation to Testing CO | Relation to Assoc. Owner |
|--------------------|-------------|--|------------------------|--------------------------|
| Employee, Managing | ██████████ | Managing Employee | None ▾ | None ▾ |
| CEO, CEO | ██████████ | Board of Directors/Officers/Principles | None ▾ | None ▾ |

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➤ **Selected Owner: CEO, CEO** SSN/EIN/TIN: ██████████ Status: Not Completed

➤ **Selected Owner: Employee, Managing** SSN/EIN/TIN: ██████████ Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- If Yes, select the relationship between the Associated Owner to the Selected Owner (e.g., the relationship to the facility enrolling, Testing CO, from the Associated Owner, Employee, Managing or CEO) [Associated Owner → Selected Owner]
 - In this example no one is related to the Selected Owner, Testing CO
- Click on > to select the relationship(s) for the next Selected Owner

CHAMPS Provider

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Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☒ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner: Testing CO SSN/EIN/TIN: Status: Completed

Selected Owner: CEO, CEO SSN/EIN/TIN: Status: Not Completed

| Assoc. Owner | SSN/EIN/TIN | Type | Relation to CEO, CEO | Relation to Assoc. Owner |
|--------------------|-------------|--------------------------------|----------------------|--------------------------|
| Employee, Managing | | Managing Employee | | |
| Testing CO | | Corporate - Charitable 501(c)3 | None | None |

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Selected Owner: Employee, Managing SSN/EIN/TIN: Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- For the next Selected Owner, CEO, some of the fields have prepopulated to None based on the relationship selection made under the previous Selected Owner, Testing CO
- Click on the drop-down arrow under Relation to CEO to select the Associated Owner's relationship to the Selected Owner

CHAMPS Provider

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Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☒ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

| Assoc. Owner | SSN/EIN/TIN | Type | Relation to CEO, CEO | Relation to Assoc. Owner |
|--------------------|-------------|--------------------------------|----------------------|--------------------------|
| Employee, Managing | | Managing Employee | None | |
| Testing CO | | Corporate - Charitable 501[c]3 | Daughter | None |

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Selected Owner: Testing CO SSN/EIN/TIN: Status: Completed

Selected Owner: CEO, CEO SSN/EIN/TIN: Status: Not Completed

Selected Owner: Employee, Managing SSN/EIN/TIN: Status: Not Completed

Page ID: dlgAddModifyOwnerRelationship(Provider)

Save Close

- In this example the Associated Owner (i.e., Employee, Managing) is the daughter of the Selected Owner, CEO
- Click on the drop-down arrow under Relation to Associated Owner to select the relationship from Selected Owner back to the Associated Owner

CHAMPS < Provider

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Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☒ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

| Assoc. Owner | SSN/EIN/TIN | Type | Relation to CEO, CEO | Relation to Assoc. Owner |
|--------------------|-------------|--------------------------------|----------------------|--------------------------|
| Employee, Managing | | Managing Employee | Daughter | |
| Testing CO | | Corporate - Charitable 501[c]3 | None | |

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> Selected Owner: Employee, Managing SSN/EIN/TIN: Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- In this example the Selected Owner, CEO is the Mother of the Associated Owner (i.e., Employee, Managing)
- Click on > to select the relationship(s) for the next Selected Owner

CHAMPS Provider

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Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☒ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

Selected Owner: Testing CO SSN/EIN/TIN: Status: Completed

Selected Owner: CEO, CEO SSN/EIN/TIN: Status: Completed

Selected Owner: Employee, Managing SSN/EIN/TIN: 231231524 Status: Completed

| Assoc. Owner | SSN/EIN/TIN | Type | Relation to Employee, Managing | Relation to Assoc. Owner |
|--------------|-------------|--|--------------------------------|--------------------------|
| CEO, CEO | | Board of Directors/Officers/Principles | Mother | Daughter |
| Testing CO | | Corporate - Charitable 501[c]3 | None | None |

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Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- For the next Selected Owner, Employee, Managing, the fields have prepopulated based on the previous relationships chosen
 - Note: The Associated Owner is showing as the mother of the Selected Owner, Employee, Managing and now the Selected Owner is showing as the daughter of the Associated Owner, CEO

CHAMPS

Provider

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Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? ☒ Yes ☐ No (Click Save to update)

Owner List

Show Owners All Go Save Filters My Filters

| | | |
|--------------------------------------|--------------|-------------------|
| > Selected Owner: Testing CO | SSN/EIN/TIN: | Status: Completed |
| > Selected Owner: CEO, CEO | SSN/EIN/TIN: | Status: Completed |
| > Selected Owner: Employee, Managing | SSN/EIN/TIN: | Status: Completed |

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- When both relationship steps are complete for each Owner Type, click Save
- Click Close

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Owners Relationships

ome address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRE

Owners Adverse Action

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:

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- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
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REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee. Corporate - Charitable 501[c]3
- At least one Board of Director/Officers/Principal is required if one of the ownership types below is selected:

| | | |
|--------------------------------|---------------------------------|----------------------------|
| Corporate - Charitable 501[c]3 | Corporate - Not Publicly Traded | Foreign, Nonresident Alien |
| Corporate - Non Charitable | Sub-contractor | Limited liability Company |
| Corporate - Publicly Traded | Holding Company | Indirect Owner |

Owners List

Filter By

And

Go

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| Owner SSN/EIN/TIN | Owner Information | Owner Type | Address | Start Date | End Date | Relationship Status | Adverse Action | Percentage owned |
|-------------------|--------------------|--|-------------------|------------|------------|---------------------|----------------|------------------|
| | Employee, Managing | Managing Employee | 100 N Capitol Ave | 12/03/2018 | 12/31/2999 | Completed | Not Completed | 0 |
| | CEO, CEO | Board of Directors/Officers/Principles | 100 N Capitol Ave | 12/03/2018 | 12/31/2999 | Completed | Not Completed | 0 |
| | Testing CO | Corporate - Charitable 501[c]3 | 100 N Capitol Ave | 12/03/2018 | 12/31/2999 | Completed | Not Completed | 100 |

Delete

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Add Other Owned Entity

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By

Go

Save Filters

My Filters

| Other Owner EIN/TIN | Other Owner Information | Address |
|---------------------|-------------------------|---------|
| No Records Found ! | | |

- The Relationship Status now shows completed for each owner
- Click Actions
- Select Owners Adverse Action

CHAMPS Provider

https://milogintpqa.michigan.gov/ - Owners with Adverse Action - Internet Explorer

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FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries or recipients. Offenses include, but are not limited to: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any misdemeanor or felonies that may result in a mandatory or permissive exclusion under State or Federal law.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the 'Owners with Adverse Action' section below for each owner.

Owners with Adverse Action

| Owner Name | Response | Comments |
|--------------------|--|----------|
| CEO, CEO | <input type="radio"/> Yes <input type="radio"/> No | |
| Employee, Managing | <input type="radio"/> Yes <input type="radio"/> No | |
| Testing CO | <input type="radio"/> Yes <input type="radio"/> No | |

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Page ID: pgEnrImntAdverseAction(Provider)

Ok Cancel

- Read through Final Adverse Legal Actions/Convictions statement,
 - For each owner listed select Yes or No
- Click Ok

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PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

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- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

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 - Corporate - Not Publicly Traded
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 - Holding Company
 - Foreign, Nonresident Alien
 - Limited liability Company
 - Indirect Owner

Owners List

Filter By

And

Go

Save Filters

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| Owner SSN/EIN/TIN | Owner Information | Owner Type | Address | Start Date | End Date | Relationship Status | Adverse Action | Percentage owned |
|-------------------|--------------------|--|-------------------|------------|------------|---------------------|----------------|------------------|
| | Employee, Managing | Managing Employee | 100 N Capitol Ave | 12/03/2018 | 12/31/2999 | Completed | No | 0 |
| | CEO, CEO | Board of Directors/Officers/Principles | 100 N Capitol Ave | 12/03/2018 | 12/31/2999 | Completed | No | 0 |
| | Testing CO | Corporate - Charitable 501(c)3 | 100 N Capitol Ave | 12/03/2018 | 12/31/2999 | Completed | No | 100 |

Delete

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Add Other Owned Entity

List Ownership Interest in other Entities reimbursable by Medicaid and/or Medicare.

Filter By

Go

Save Filters

My Filters

| Other Owner EIN/TIN | Other Owner Information | Address |
|---------------------|-------------------------|---------|
| No Records Found ! | | |

- The Adverse Action column will show Yes or No indicating it's complete
- Click Close

MDHHS

Michigan Department of Health & Human Services



Provider ▾

Claims,Uat ▾

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Print

Help

New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing

Close

Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 8: Associate Billing Agent | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 10: Add Taxonomy Details | Required | | | Incomplete | |
| Step 11: Associate MCO Plan | Optional | | | Incomplete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 9 is complete
- Click on Step 10: Add Taxonomy Details

Application ID: 20171106185367

Name: Testing

Close Add

Taxonomy List

Filter By ▾

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Save Filters

My Filters ▾

Taxonomy Code

Description

Start Date

End Date

□ ▲▼

▲▼

▲▼

▲▼

No Records Found !

- Click Add

CHAMPS

Provider

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171106185367 Name: Testing

Add Taxonomy

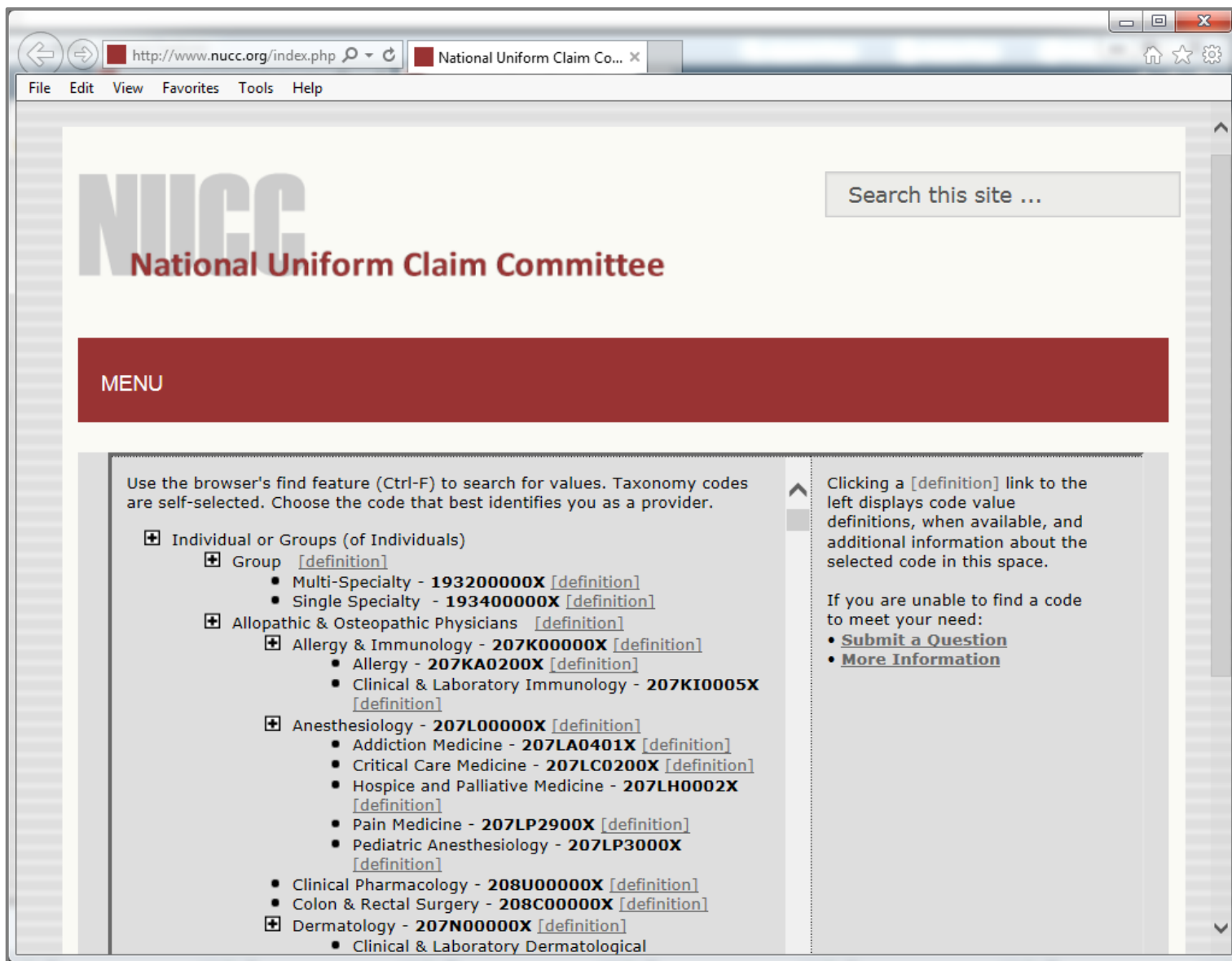
Taxonomy Code: (Click here for Taxonomy List)

Description:

Start Date: * End Date:

Confirm Taxonomy Ok Cancel

- Enter in Taxonomy Code or click on () next to the words, Click here for Taxonomy List, to look up appropriate taxonomy code



- After clicking (1) the [National Uniform Claim Committee](http://www.nucc.org/index.php) webpage will pop-up
- Press (CTRL+F) to search for appropriate taxonomy code



Provider ▾

https://milogintp.michigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID: 20171106185367

Name: Testing

Add Taxonomy

Taxonomy Code: * [\(Click here for Taxonomy List\)](#)

Location: 01- ▾ *

Description:

Start Date:  *

End Date: 

- Enter Start Date *(Please Note: Must be current date or date of application)*
- Click Confirm Taxonomy
- Click Ok



Provider ▾



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New Enrollment > FAO Enrollment

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Close

Add

Taxonomy List

Filter By



Go

Save Filters

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Taxonomy Code

Description

Start Date

End Date



Δ ▾



Δ ▾



Δ ▾



Δ ▾

☐ 332B00000X

Durable Medical Equipment & Medical Supplies

11/07/2017

12/31/2999



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- The Taxonomy Code information will now be displayed
- Click Close



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Close



Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
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| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
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| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 8: Associate Billing Agent | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 10: Add Taxonomy Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 11: Associate MCO Plan | Optional | | | Incomplete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 10 is complete
- Click on Step 11: Associate MCO Plan (Please Note: This step is optional)


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New Enrollment
FAO Enrollment

Application ID: 20171106185367
Name: Testing

Close
Add

MCO Plan List

Filter By
Go
Save Filters
My Filters

| Plan ID | Plan Name | Business Status | Business Status Start Date | Business Status End Date | Association Start Date | Association End Date | Program Description |
|--------------------|-----------|-----------------|----------------------------|--------------------------|------------------------|----------------------|---------------------|
| No Records Found ! | | | | | | | |

- Step is optional, if you do not work with a Managed Care Organization (MCO) plan, click Close



Provider ▾



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New Enrollment > FAO Enrollment

Application ID: 20171106185367

Name: Testing

Close

Add



MCO Plan List

Filter By



Go

Save Filters

My Filters ▾

| Plan ID | Plan Name | Business Status | Business Status Start Date | Business Status End Date | Association Start Date | Association End Date | Program Description |
|-----------------------------|-----------|-----------------|----------------------------|--------------------------|------------------------|----------------------|---------------------|
| <input type="checkbox"/> ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ |

No Records Found !

- If choosing to add an MCO Plan;
- Click Add to associate an MCO plan

Application ID: 20171106185367

Name: Testing

Associate MCO Plan

Click on the 'Confirm/Search Plan' button to search for a MCO Plan or confirm the Plan ID entered



Please associate only to plans with which you have a signed contract

Plan ID: *

Plan Name:

Program Name:

Program Description:

Association Start Date:  *Association End Date: 

- To locate the MCO Plan , click Confirm/Search Plan

Application ID: 20171106185367

Name: Testing

MCO Plan Search List

Filter By ▾

Go

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| Plan ID | Plan Name | Business Status | Business Status Start Date | Business Status End Date | Program Name | Program Type |
|--------------------------|-----------|-----------------|----------------------------|--------------------------|--------------|---|
| ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ |
| <input type="checkbox"/> | | Active | 12/04/2014 | 12/31/2999 | ICO-MC | Managed Care Comprehensive Medical Program Type |
| <input type="checkbox"/> | | Active | 12/04/2014 | 12/31/2999 | ICO-MC | Managed Care Comprehensive Medical Program Type |
| <input type="checkbox"/> | | Active | 12/04/2014 | 12/31/2999 | ICO-MC | Managed Care Comprehensive Medical Program Type |
| <input type="checkbox"/> | | Active | 12/04/2014 | 12/31/2999 | ICO-MC | Managed Care Comprehensive Medical Program Type |
| <input type="checkbox"/> | | Active | 12/04/2014 | 12/31/2999 | ICO-MC | Managed Care Comprehensive Medical Program Type |
| <input type="checkbox"/> | | Active | 12/04/2014 | 12/31/2999 | ICO-MC | Managed Care Comprehensive Medical Program Type |
| <input type="checkbox"/> | | Active | 12/21/1993 | 12/31/2999 | MHP | Managed Care Comprehensive Medical Program Type |
| <input type="checkbox"/> | | Active | 04/04/2005 | 12/31/2999 | MHP | Managed Care Comprehensive Medical Program Type |

Select

Close

Confirm Search Plan

OK

Cancel

- Check the box next to the MCO Plan you want to select
(Please Note: There is more than one page of MCO plans; you may select more than one)
- Click Select

Application ID: 20171106185367

Name: Testing

Associate MCO Plan

Click on the 'Confirm/Search Plan' button to search for a MCO Plan or confirm the Plan ID entered

Please associate only to plans with which you have a signed contract

Plan ID: *Plan Name:

Program Name: MHP

Program Description: ManagedCareProgram

Association Start Date: 11/20/2017 *Association End Date: 12/31/2999

- MCO Plan information will populate
- Click Ok



Provider



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New Enrollment > FAO Enrollment

Application ID: 20171106185367

Name: Testing

Close

Add

MCO Plan List

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| Plan ID | Plan Name | Business Status | Business Status Start Date | Business Status End Date | Association Start Date | Association End Date | Program Description |
|--------------------------|-----------|-----------------|----------------------------|--------------------------|------------------------|----------------------|---------------------|
| <input type="checkbox"/> | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ |
| <input type="checkbox"/> | | Active | 12/21/1993 | 12/31/2999 | 11/15/2017 | 12/31/2999 | ManagedCareProgram |

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- MCO Plan information has been associated
- Click Close



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Name: Testing

Close



Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 8: Associate Billing Agent | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 10: Add Taxonomy Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 11: Associate MCO Plan | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 12: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 11 is complete
- Click on Step 12: 835/ERA Enrollment Form (Please Note: This step is optional)

CHAMPS < Provider >

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> New Enrollment > F/AQ Enrollment

Application ID: 20171106185367 Name: Testing

Close Submit Print Help

ERA ENROLLMENT FORM

PROVIDER INFORMATION

Provider Name: _____

Doing Business As Name (DBA): Testing

Provider Address

Street: 320 S Walnut St State/Province: MICHIGAN

City: Lansing Zip Code/Postal Code: 48933

Country Code: UNITED STATES

PROVIDER IDENTIFIERS

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN): _____

National Provider Identifier (NPI): _____

Other Identifier(s) _____

Assigning Authority: _____ Trading Partner ID: _____

Provider License Details

Provider License No: _____ License Issuer: _____

Provider Type: SUPPLIERS

Provider Taxonomy Code: _____

PROVIDER CONTACT INFORMATION

Provider Contact Name

Contact: Tester,Testing Title: Managing Employee

Telephone Number: 8888888888 Telephone Number Extension: _____

PROVIDER AGENT INFORMATION

Provider Agent Name: _____

Agent Address

Street: _____ State/Province: _____

City: _____ Zip Code/Postal Code: _____

Country Code: _____

Provider Agent Contact Name

Provider Agent Contact Name: _____ Title: _____

Telephone Number: _____ Telephone Number Extension: _____

Email Address: _____ Fax Number: _____

FEDERAL AGENCY INFORMATION (Not applicable at this time)

Federal Program Agency Name: _____ Federal Program Agency Identifier: _____

Federal Agency Location Code: _____

RETAIL PHARMACY INFORMATION(Not applicable at this time)

Pharmacy Name

Pharmacy Name: _____ Chain Number: _____

Parent: _____ Organization ID: _____

Payment Center ID: _____

NCPDP Provider ID Number: _____

Medicaid Provider Number: _____

- Step is optional, fill out if provider would like to directly receive their 835 (i.e., electronic remittance advice (ERA))
(Please Note: within step 2 providers would have needed to select Yes, to question “Accept 835?”)
- Complete all fields marked with an asterisk (*)

ELECTRONIC REMITTANCE ADVISE INFORMATION

Preference for Aggregation of Remittance Data(e.g., Account Number Linkage to Provider Identifier)

☐ NPI ☒ TAX ID *

MI Medicaid enumerates by Tax ID only.

Method of Retrieval: ☒ *

ELECTRONIC REMITTANCE ADVISE CLEARINGHOUSE INFORMATION (Not applicable at this time)

ClearingHouse Name:

ClearingHouse Contact Name

ClearingHouse Contact Name:

Telephone Number:

Email Address:

ELECTRONIC REMITTANCE ADVISE VENDOR INFORMATION (Not applicable at this time)

Vendor Name:

Vendor Contact

Vendor Contact Name:

Telephone Number:

Email Address:

SUBMISSION INFORMATION

Reason for Submission

☐ Cancel Enrollment ☐ Change Enrollment ☒ New Enrollment *

Authorized Signature

Electronic Signature of Person Submitting Enrollment:

☐ Authorization Agreement-By selecting the checkbox above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below.

Authorization Agreement

By signing this request, I am authorizing the Michigan Department Of Health and Human Services to establish an 835/ERA account for the Tax ID listed above and for 835/ERA files to be transmitted electronically to the designated entity.

Written Signature of Person Submitting Enrollment:

Printed Name of Person Submitting Enrollment:

Printed Title of Person Submitting Enrollment:

Submission Date: 11/07/2017

Requested ERA Effective Date:

(Once approve the next paycycle date.)

- Complete all fields marked with an asterisk (*)



Provider ▾

▾

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Name: Testing

Close

Submit

Print

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ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION (Not applicable at this time)



Vendor Name:

Vendor Contact

Vendor Contact Name:

Telephone Number:

Email Address:



SUBMISSION INFORMATION



Reason for Submission

☐ Cancel Enrollment ☐ Change Enrollment ☒ New Enrollment *

Authorized Signature

Electronic Signature of Person Submitting Enrollment:

☐ Authorization Agreement-By selecting the checkbox above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below.

Authorization Agreement

By signing this request, I am authorizing the Michigan Department Of Health and Human Services to establish an 835/ERA account for the Tax ID listed above and for 835/ERA files to be transmitted electronically to the designated entity.

Written Signature of Person Submitting Enrollment:

Printed Name of Person Submitting Enrollment:

- Click Submit
- Click Close



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Close



Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
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| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
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| Step 9: Add Provider Controlling Interest/Ownership Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 10: Add Taxonomy Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 11: Associate MCO Plan | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 12: 835/ERA Enrollment Form | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 13: Fee Payment | Optional | | | Incomplete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 12 is complete
- Click on Step 13: Fee Payment



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Name: Testing

Close

Add

Fee Payment List

Filter By ▾

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Save Filters

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| Payment Id ▲▼ | Payment Reason ▲▼ | Payment Amount ▲▼ | Fee Option ▲▼ | Payment Made To ▲▼ | Payment Status ▲▼ | Confirmation Number ▲▼ | Payment Date ▲▼ |
|--------------------|----------------------|----------------------|------------------|-----------------------|----------------------|---------------------------|--------------------|
| No Records Found ! | | | | | | | |

- This step will house institutional providers application fee. Only certain specialties are required to pay this fee. Providers will have the ability to pay the fee from within CHAMPS or attest they have already paid another State fee or Medicare.



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Application ID: 20181204526214

Name: Testing

Close



Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

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| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 8: Associate Billing Agent | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
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| Step 13: Fee Payment | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 14: Upload Documents | Optional | | | Incomplete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 13 is complete
- Click on Step 14: Upload Documents (Please Note: This step is optional)

Application ID: 20171106185367

Name: Testing

Close

Document List

Add

Filter By



Go

Save Filters

My Filters ▾

| Document ID | Document Type | Document Name | File Name | Start Date | End Date | Uploaded By | Uploaded Date | Status |
|-----------------------------|---------------|---------------|-----------|------------|----------|-------------|---------------|--------|
| <input type="checkbox"/> ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ | ▲▼ |

No Records Found !

- This step is optional, if documentation needs to be uploaded, click Add
- If not, click Close

Application ID: 20171106185367

Name: Testing

Upload Document

Document Type:

—SELECT—

Certification

Contract

General

License

*

Associated MCO ID:

File Name:

Browse...

Start Date:

End Date:

Remark:

Document Name:

▼

*

Program Name:

▼

✓ OK

Cancel

- If provider chooses to upload a document;
- Select the document type and document name
- Click Browse to find the saved document on your computer
- Enter any other additional information
- Click Ok

Application ID: 20171106185367

Name: Testing

Close

Document List

Add

Filter By



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| Document ID ▲▼ | Document Type ▲▼ | Document Name ▲▼ | File Name ▲▼ | Start Date ▲▼ | End Date ▲▼ | Uploaded By ▲▼ | Uploaded Date ▲▼ | Status ▲▼ |
|--------------------------|---------------------|---------------------|-----------------|------------------|----------------|-------------------|---------------------|--------------|
| <input type="checkbox"/> | Certification | Board Certification | | | | | 11/15/2017 | In Process |

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- The documentation has been added
- To return to the enrollment steps, click Close



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Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

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|---|----------|------------|------------|------------|-------------|
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| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
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| Step 13: Fee Payment | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 14: Upload Documents | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 15: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 14 is complete
- Click on Step 15: Complete Enrollment Checklist



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[New Enrollment](#) > [FAO Enrollment](#) > [Provider Check List](#)

Application ID: 20181204526214

Name: Testing

Provider Checklist

| Question ▲▼ | Answer ▲▼ | Comments ▲▼ |
|--|--|----------------------|
| Do you need to request a Retro Enrollment Date? If Yes, enter the requested Retro Enrollment Date in the comment field. | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| Are you currently excluded from any State program? | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| Are you currently excluded from any Federal program? | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| Have you ever had a criminal or health-related conviction? | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| Have you ever had a judgment under any false claims act? | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| Have you ever had a program exclusion/debarment? | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| Have you ever had a civil monetary penalty? | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| Do you have ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step. | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| Do you accept new patients? | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| Have you had any malpractice settlement, judgment, or agreement? If yes, enter dollar amount(s) and date(s). | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| Do you need eligibility data (via HIPAA 270/271 Batch transaction) for DOS older than 1 year to complete a Medicare DSH audit? Selecting Yes acknowledges that any 270 - eligibility inquiry you submit with a DOS older than 1 year will only be used Medicare DSH validation and for services related to Inpatient Hospital. | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| All providers are considered for the Beneficiary Monitoring Program. Do you object to this participation? | Not Completed <input type="button" value="v"/> | <input type="text"/> |
| If this enrollment is for change of ownership (CHOW) with a new NPI, please enter the old NPI in the comment box | Not Completed <input type="button" value="v"/> | <input type="text"/> |

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- Answer the questions in the Provider Checklist as appropriate
- Add Comments when necessary
- Click Save
- Click Close



Provider ▾



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Application ID: 20181204526214

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Close



Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 8: Associate Billing Agent | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 10: Add Taxonomy Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 11: Associate MCO Plan | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 12: 835/ERA Enrollment Form | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 13: Fee Payment | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 14: Upload Documents | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 15: Complete Enrollment Checklist | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 16: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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- Step 15 is complete
- Click on Step 16: Submit Enrollment Application for Approval

(Please Note: If you chose not to complete optional steps you can still submit your application)

You must complete step 16 to submit your application



Provider ▾



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Final Submission



Application ID: 20181204526214

EnrollmentType: Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)

The information submitted for enrollment shall be verified and reviewed by the State.

During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct (Private and Confidential).



Application Document Checklist



Forms/Documents

Special Instructions

Source

Required



No Records Found !

- Final Submission: Click Next

Application ID: 20181204526214

Name: Testing

 After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.**Medical Assistance Provider Enrollment & Trading Partner Agreement - Conditions**

In applying for enrollment as a provider or trading partner in the Medical Assistance Program (and programs for which the Michigan Department Of Health and Human Services (MDHHS) is the fiscal intermediary), I represent and certify as follows:

1. The applicant, and the employer (if applicable), certify that the undersigned has/have the authority to execute this Agreement.
2. Enrollment in the Medical Assistance Program does not guarantee participation in MDHHS managed care programs nor does it replace or negate the contract process between a managed care entity and its providers or subcontractors.
3. All information furnished on this Medical Assistance Provider Enrollment & Trading Partner Agreement form is true and complete.
4. The providers and fiscal agents of ownership and control information agree to provide proper disclosure of provider's owners and other persons criminal related to Medicare, Medicaid or Title XX involvement. [42 CFR 455.100]
5. The applicant and the employer agree to provide proper disclosure of any criminal convictions related to Medicare (Title XVIII), Medicaid (Title XIX), and other State Health Care Programs (Title V, Title XX, and Title XXI) involvement since the inception of Medicare, Medicaid, or Title XX programs. [42 CFR 455.106 and 42 U.S.C. § 1320a-7]
6. Before billing for any medical services I render, I will read the Medicaid Provider Manual from the Michigan Department Of Health and Human Services (MDHHS). I also agree to comply with 1) the terms and conditions of participation noted in the manual, and 2) MDHHS's policies and procedures for the Medical Assistance Program contained in the manual, provider bulletins and other program notifications.
7. I agree to comply with the provisions of 42 CFR 455.104, 42 CFR 455.105, 42 CFR 431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation in the Medical Assistance Program is allowed.
8. I agree to comply with the requirements of Section 6032 of the Deficit Reduction Act of 2005, codified at section 1902 (a)(68) of the Social Security Act which relates to the conditions and requirements of "Employee Education About False Claims Recovery."
9. I agree that, upon request and at a reasonable time and place, I will allow authorized state or federal government agents to inspect, copy, and/or take any records I maintain pertaining to the delivery of goods and services to, or on behalf of, a Medical Assistance Program beneficiary. These records also include any service contract(s) I have with any billing agent/service or service bureau, billing consultant, or other healthcare provider.
10. I agree to include a clause in any contract I enter into which allows authorized state or federal government agents access to the subcontractor's accounting records and other documents needed to verify the nature and extent of costs and services furnished under the contract.
11. I understand that payment for services billed under my National Provider Identifier (NPI) number will be made directly to me, unless Item 20 (below) applies.
12. I am not currently suspended, terminated, or excluded from the Medical Assistance Program by any state or by the U.S. Department of Health and Human Services.
13. I agree to comply with all policies and procedures of the Medical Assistance Program when billing for services rendered. I also agree that disputed claims, including overpayments, may be adjudicated in administrative proceedings convened under Act No. 280 of the Public Acts of 1939, as amended, or in a court of competent jurisdiction. I further agree to reimburse the Medical Assistance Program for all overpayments, and I acknowledge that the Medicaid Audit System, which uses random sampling, is a reliable and acceptable method for determining such overpayments.
14. I agree to comply with the privacy and confidentiality provisions of any applicable laws governing the use and disclosure of protected health information, including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR Parts 160 and 164, Subparts A and E). I also agree to comply with the HIPAA security regulations, as applicable, for electronic protected health information by the compliance date, which is currently April 21, 2005 (45 CFR Parts 160 and 164, Subparts A and C). If I am an electronic biller, I will abide by the Trading Partner Provision Section of this Agreement, and the HIPAA regulations regarding electronic transactions and code sets, as applicable (45 CFR Parts 160 and 162).
15. This Agreement shall be governed by the laws of the State of Michigan and applicable federal law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
16. The provisions of this Agreement are severable. If any provision is held or declared to be illegal, invalid or unenforceable, the remainder of the Agreement will continue in full force and effect as though the illegal, invalid or unenforceable provision had not been contained in this Agreement.
17. Failure or delay on the part of either party to exercise any right, power, privilege, or remedy in this Agreement will not constitute a waiver. No provision of this Agreement may be waived by either party except in writing and signed by an authorized representative of the party requesting the waiver.

Condition 18 applies to nursing facilities only:

18. If the nursing facility named on the Medical Assistance Provider Enrollment & Trading Partner Agreement is sold, the seller will notify MDHHS of the sale at least ninety (90) days prior to the expected sale date. Further, it is understood that the sale will not be recognized for reimbursement purposes under the Medical Assistance Program until ninety (90) days after such notification. Provisions of 42 CFR 413.135(f) will be retrospectively satisfied at that time. Any exception must be approved in writing by MDHHS. The new owner/provider must receive Medicare certification for all Medicaid-only beds in the facility within one year from the date of purchase of an operating nursing facility or from the date of reopening a previously closed nursing facility.

- Read through the entire list of Terms and Conditions

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 After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

Medicare certification for all Medicaid-only beds in the facility within one year from the date of purchase of an operating nursing facility or from the date of reopening a previously closed nursing facility.

Medical Assistance Provider - Employer/Employee Conditions

19. The applicant is employed by the business listed, now referred to as the "employer", to provide Medical Assistance Program services to eligible beneficiaries at the service address listed.
20. The employer shall use the applicant's NPI when billing for Medical Assistance Program services provided by the applicant to eligible beneficiaries.
21. The applicant, as a condition of employment, agrees that the employer shall directly receive the payments made in his/her name by the Medical Assistance Program for services billed and paid for eligible beneficiaries.
22. The employer and the applicant shall advise MDHHS within thirty (30) days after any change(s) in the employment relationship.
23. The employer and the applicant agree to be jointly and severally liable for any overpayments billed and paid under Act No. 280 of the Public Acts of 1939, as amended, for services provided by the applicant to eligible beneficiaries.

Trading Partner Provisions

The MDHHS and its Trading Partner desire to facilitate the exchange of healthcare transactions ("Transactions") by electronically transmitting and receiving data in agreed formats in substitution for conventional paper-based documents.

1. Companion Documents; Standards; Other Documentation.

MDHHS makes available certain inbound and outbound Electronic Data Interchange (EDI) transaction sets/formats and associated version. From time to time during the term of this Agreement, MDHHS may modify supported transaction sets/formats. In submitting Transactions to MDHHS, the Trading Partner agrees to conform to MDHHS-issued provider publications and MDHHS Companion Guides as amended from time to time. The MDHHS Companion Guides, incorporated by reference herein, contain specific instructions for conducting each Transaction and as such supplement Implementation Guides issued under the Standards for Electronic Transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended. The MDHHS Companion Guides are not intended to be complete billing instructions and do not alter or replace applicable physician guides or other healthcare provider billing publications issued by MDHHS or by other third party payers. The Trading Partner agrees to comply with the requirements set forth in the applicable MDHHS Companion Guides. The Trading Partner, or its vendor, or other authorized technical representative responsible for EDI software will document Trading Partner Information, data formats and related versions, trading partner identifiers, and other information MDHHS requires to receive and transmit specific Transactions supported by MDHHS.

2. Support.

As to software, equipment, and services associated with each party's performance under this Agreement, the parties agree to provide support services sufficient for Transactions to be exchanged. Each party will assist the other in establishing and/or maintaining support procedures, and will complete appropriate problem determination procedures prior to contacting the other with a support related matter. The parties agree to use all commercially reasonable efforts to avoid and resolve performance and unavailability issues. Each party will perform remedial action, as requested by the other, to assist in problem resolution. Each party, at its own expense, shall provide and maintain the equipment, software, services, and testing necessary to effectively and reliably transmit and receive transactions.

3. Data Retention.

MDHHS will log all Transactions for the purpose of problem investigation, resolution, and servicing. The Trading Partner is responsible for maintaining and retaining its own records of data submitted to MDHHS. Trading Partners who are healthcare providers will ensure that electronic healthcare claims submitted to MDHHS can be readily associated and identified with the correct patient medical and business office records, and that these records are maintained in a manner that permits review, and for the time period as may be required by MDHHS or other third party payer responsible for claim payment.

4. Proper Receipt and Verification for Transactions.

Upon proper receipt of any ANSI ASC X12N Standard Transaction, the receiving party shall promptly and properly transmit a functional acknowledgement in return, unless otherwise specified. The functional and interchange acknowledgements must be accepted and reviewed, when applicable, to confirm the receipt of a Transaction. The ability to send or receive functional acknowledgements is applicable only to ANSI ASC X12N Standard Transactions. Additionally, MDHHS originated outbound Transactions must be accepted and reviewed, when appropriate, to obtain MDHHS's response to specific inbound Transactions. The acknowledging party does not attest to the accuracy of the data contained in the transmission; rather, it only confirms receipt of the transmission.

- Continue to read through the entire list of Terms and Conditions

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Name: Testing

 After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

other third party payer responsible for claim payment.

4. Proper Receipt and Verification for Transactions.

Upon proper receipt of any ANSI ASC X12N Standard Transaction, the receiving party shall promptly and properly transmit a functional acknowledgement in return, unless otherwise specified. The functional and interchange acknowledgements must be accepted and reviewed, when applicable, to confirm the receipt of a Transaction. The ability to send or receive functional acknowledgements is applicable only to ANSI ASC X12N Standard Transactions. Additionally, MDHHS originated outbound Transactions must be accepted and reviewed, when appropriate, to obtain MDHHS's response to specific inbound Transactions. The acknowledging party does not attest to the accuracy of the data contained in the transmission; rather, it only confirms receipt of the transmission.

5. Liability.

MDHHS shall not be responsible to the Trading Partner nor anyone else for any damages caused by loss, delay, rejection, or any misadventure affecting such electronic information. In addition, MDHHS shall be excused from performing any EDI service or function, in whole or in part, as a result of an act of God, war, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control, including shortages or fluctuations in electrical power, heat, light, or air conditioning. MDHHS's sole liability to the Trading Partner or to any other person or entity in connection with MDHHS's responsibilities under this Agreement shall be to reprocess information supplied by the Trading Partner or duplicate information from a backup supplied by the Trading Partner upon MDHHS's request which shall be the sole remedy against MDHHS for claimed damage or injury of any nature. MDHHS shall not be liable for any indirect, special, or consequential damages arising out of any access, use, or any reliance upon, the EDI services MDHHS provides to the Trading Partner. MDHHS assumes no responsibility for claims preparation, review, information accuracy, pricing, adjudication, payment, adjustment, accounting, reconciliation or any other matter related to the claims transmitted for delivery to other third party payers. The Trading Partner agrees to defend, indemnify, and hold harmless MDHHS, its Trading Partners, officers, agents, employees, assigns and successors from and against any and all claims, losses, and actions, including all costs and reasonable attorney fees, arising out of electronic Transactions the Trading Partner submits to MDHHS.

6. Standard Transactions.

All Standard Transactions, as defined by HIPAA, will be conducted by the parties using only code sets, data elements, and formats specified by the Transaction Rules and instructions in the MDHHS Companion Guides. The parties agree that when conducting Standard Transactions, they will not change the definition, data condition, or use of a data element or segment in a standard, add data elements or segments to the maximum defined data set, use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications.

7. Testing.

All new Trading Partners will cooperate with MDHHS upon request in testing processes prior to submission of production data. Existing Trading Partners will cooperate with MDHHS upon request in testing processes for any changes in submission format prior to submission of production files. MDHHS will notify the Trading Partner of the effective date for production data after successful testing.

8. Data and Network Security.

The parties agree to use reasonable security measures to protect the integrity of data transmitted under this Agreement and to protect this data from unauthorized access. The Trading Partner shall comply with MDHHS data and network security requirements, which may change from time to time and as may be required by the HIPAA security regulations.

9. Automatic Amendment for Regulatory Compliance.

This Agreement will automatically be amended to comply with any final regulation or amendment to a final regulation adopted by the U.S. Department of Health and Human Services concerning the subject matter of this Agreement upon the effective date of the final regulation or amendment.

10. Miscellaneous.

Provisions 3 and 8 shall survive termination of this Agreement.

The Trading Partner will notify MDHHS of any changes in trading partner information supplied including, but not limited to, the name of the service bureau, billing service, recipient of remittance file, or provider code at least 30 calendar days prior to the effective date of such change.

☐ By checking this, I certify that I have read and that I agree and accept the enrollment conditions in the Medical Assistance Provider Enrollment & Trading Partner Agreement.

- Check the box at the end to agree to the Terms and Conditions
- Click Submit Application



Provider ▾



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New Enrollment > FAO Enrollment

Application ID: 20181204526214

Name: Testing

Your Application Number 20181204526214 has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

Close

Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|----------|-------------|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 8: Associate Billing Agent | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 9: Add Provider Controlling Interest/Ownership Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 10: Add Taxonomy Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 11: Associate MCO Plan | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 12: 835/ERA Enrollment Form | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 13: Fee Payment | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 14: Upload Documents | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 15: Complete Enrollment Checklist | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 16: Submit Enrollment Application for Approval | Required | 12/04/2018 | 12/04/2018 | Complete | |

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- Step 16 is now complete and the application has been submitted to the State for review
- Take note of your Application ID for further tracking
- Click Close

(Please Note: Optional steps may show as incomplete if you chose not to complete. This is ok.)

Track Existing Application

How to track a submitted application within CHAMPS

CHAMPS

Provider

Tester, Testing

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Provider Enrollment

PROVIDER ENROLLMENT

New Enrollment

Track Application

| | |
|-------------------|-------------------------------------|
| New Enrollment | Enroll As A New Provider |
| Track Application | Track Existing Provider Application |

- Select Provider tab
- Click Track Application

Close

Next

Track Existing Application

Please provide the Application ID to track your application.

Application ID: *

Request Access to Home Help Provider Info

Click the below link if you are an Existing Home Help Individual or Agency accessing CHAMPS system for the first time. provide the Application ID to track your application.

[Home Help Providers requesting access to their Information.](#)

- Fill in Application ID
- Click Next

Close Submit

Verify Application Details

For Additional security, please enter following information:

EIN/TIN: *

Phone: *

Owner SSN: * 

Owner Date Of Birth:  *

- Complete all fields marked with an asterisk (*)
- Click Submit

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Your application is currently In-Review by the Provider Enrollment Unit. You cannot make any modifications to your enrollment information at this time.

X

Close

Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|----------|-------------|
| Step 1: Provider Basic Information | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 2: Add Locations | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 3: Add Specialties | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 4: Associate Billing Provider/Other Associations | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 5: Add License/Certification/Other | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 6: Add Additional Information | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 7: Add Mode of Claim Submission/EDI Exchange | Required | 12/04/2018 | 12/04/2018 | Complete | |
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| Step 9: Add Provider Controlling Interest/Ownership Details | Required | 12/04/2018 | 12/04/2018 | Complete | |
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| Step 11: Associate MCO Plan | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 12: 835/ERA Enrollment Form | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 13: Fee Payment | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 14: Upload Documents | Optional | 12/04/2018 | 12/04/2018 | Complete | |
| Step 15: Complete Enrollment Checklist | Required | 12/04/2018 | 12/04/2018 | Complete | |
| Step 16: Submit Enrollment Application for Approval | Required | 12/04/2018 | 12/04/2018 | Complete | |

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- Confirmation your Provider Enrollment Application has been submitted and is being reviewed by the state
- Click Close

Provider Enrollment Final Steps

- Please allow the State time to review the Provider Enrollment Application.
- After the State has looked over the Provider Enrollment Application Providers will receive a letter letting them know whether they have been approved or denied.
 - Letter is sent to the Correspondence address provided in the Provider Enrollment Application.

Provider Resources

- **MDHHS website:** www.michigan.gov/medicaidproviders
- **We continue to update our Provider Resources, just click on the links below:**
 - [Listserv Instructions](#)
 - [Medicaid Alerts](#)
 - [Update Other Insurance NOW!](#)
 - [Medicaid Provider Training Sessions](#)
- **SIGMA:**
 - New Providers must register with SIGMA
 - Please visit: Michigan.gov/SIGMAVSS
- **Provider Enrollment:**
 - ProviderEnrollment@Michigan.gov or 1-800-292-2550

Thank you for participating in the Michigan Medicaid Program